Bill Codd, PT
Mike Lauffer, PT

B&B Physical Therapy
6415 North Monroe
Spokane, WA 99208
(509) 327-4867

Lanaia Severino, PT
Mary Ellen Anton, PT/ATC
Renēe Compton, PTA/ATC

Patient Information (Returning Patient: Y____ N____)

Patient's Full Name: _____
(First) (MI) (Last)

SSN: _____ Age: _____Birth date: _____Sex: M _____ F _____

Street Address: _____
(City) (State) (Zip)

Occupation: _____Employer/School: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: _____

Marital Status: _____ Spouse or Guardian Name: _____

Emergency Contact Name: _____ Phone: (____)_____

Primary Care Provider Name: _____ Referring Provider: _____

Work Related: Y___ N___ Date of Injury or Onset of Illness: _____

Have You Hired an Attorney: Y_____ N_____ If Yes, Attorney's Name: _____

Insurance Information

Primary Insurance Company: _____ Subscriber: _____

Policy/Claim Number: _____ Group Number: _____

Secondary Insurance Company: _____ Subscriber: _____

Policy Number: _____ Group Number: _____

Do any apply to you? (Circle yes or no)

Swallowing Problems	YES/NO	Heart Trouble/Pacemaker	YES/NO
Thyroid	YES/NO	Stroke	YES/NO
High Blood Pressure	YES/NO	Cancer/Tumor	YES/NO
Emphysema	YES/NO	Anemia	YES/NO
Osteoporosis	YES/NO	Bleeding Disorder	YES/NO
Ulcers	YES/NO	Arthritis	YES/NO
Allergy/Asthma	YES/NO	Kidney/Bladder Trouble	YES/NO
Epilepsy/Convulsions	YES/NO	Birth Defects	YES/NO
Diabetes	YES/NO	Pacemaker/Defibrillator	YES/NO

Other_____

I, the undersigned, certify that the above information is true to the best of my knowledge.

Signature: _____ Date: _____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE TODAY?_____

For Office Use Only
PT: _____
ICD9: _____

PF-2000 **Consent to Use and Disclosure of Protected Health Information**

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by B&B Physical Therapy or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of yow your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use of Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information. B&B Physical Therapy may or may not agree to restrict the use or discloser of your protected health information.
If B&B Physical Therapy agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Signature
I have reviewed this consent form and give my permission to B&B Physical Therapy to use and disclose my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Relationship to Patient

I have received a copy of the notice of privacy practices for B&B Physical Therapy.

_____ _____
Signature of Patient Date